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AUTO INSURERS AGAIN SEEK DISMISSAL OF *IN RE AUTO BODY SHOP ANTITRUST LITIGATION*

James M. Burns

In early March, the auto insurer defendants in the *In re Auto Body Shop Antitrust Litigation* renewed their motions seeking the dismissal of plaintiffs' action, this time directed at plaintiffs' Second Amended Complaint. The insurer defendants urged the Court to dismiss the action with prejudice, maintaining that, despite three attempts, the plaintiff auto body shops have still failed to include sufficient facts to make their claim of conspiracy plausible.

The action, commenced well over year ago as *A&E Auto Body v. 21st Century Centennial Insurance Co.* and subsequently transformed into a multidistrict litigation proceeding (*In re Auto Body Shop Antitrust Litigation*, MDL 2557) after similar cases were filed in a multitude of states, centers upon a claim that many of the leading auto insurers in the country conspired to reduce rates for the repair of damaged vehicles and to steer insureds away from auto repair shops that refused to accept lower reimbursement rates for their services. The cases were consolidated before Judge Gregory Presnell (M.D. Fla.) in late 2014, and in early 2015 Judge Presnell dismissed plaintiffs' First Amended Complaint, finding that the plaintiffs had failed to plead an antitrust conspiracy with the degree of specificity required under *Bell Atlantic v. Twombly*, 550 U.S. 544 (2007).

In February, plaintiffs filed their Second Amended Complaint, seeking to cure the deficiencies in the complaint identified in Judge Presnell's prior rulings. In March, the defendants filed several new motions to dismiss the action. One group of defendants (including State Farm, Allstate, Progressive and 21st Century) maintained that the plaintiffs' allegations *still* failed to include sufficient factual support to plead an actionable antitrust conspiracy, which they described as the "crucial question" in the case. Claiming that the plaintiffs' allegations demonstrated nothing more that "parallel conduct" towards the plaintiffs, not agreement, these defendants renewed their request to have the action dismissed as to them. Another group of defendants (which includes Hartford, Nationwide and Zurich American) went a step further, arguing that the plaintiffs had failed to allege *any* material facts specifically about them, despite Judge Presnell's express instruction in his prior dismissal order in January (without prejudice, on that occasion) that plaintiffs provide detailed allegations about each defendant's involvement in the alleged conspiracy. Finally, one defendant (Old Republic) filed a separate motion not only seeking dismissal, but sanctions as well, based on the claim that the plaintiffs

had been put on notice by the Court that particularized allegations as to each defendant's alleged conduct was required, and that plaintiffs' failure to include any additional factual support for their claims against Old Republic was sanctionable conduct.

In late March, the plaintiffs filed an "omnibus" response to all of the defendants' motions, arguing that dismissal of the case at this juncture was not warranted. Asserting that "the Second Amended Complaint complies in every respect with the Court's [January] Order," the plaintiffs urged the Court to permit them to proceed into discovery. Specifically, the plaintiffs maintained that the parallel conduct alleged in the Second Amended Complaint constitutes "circumstantial evidence of conspiracy" and that the Supreme Court has never expressly held how many "plus factors" supporting a claim of conspiracy are required to satisfy a plaintiff's pleading obligations. Plaintiffs contended, therefore, that they are not required to "set out specific facts establishing the time, place or persons involved in the conspiracy" nor are they required to allege an "express agreement." Instead, they maintained, their allegations of parallel conduct, coupled with their allegations about the defendants' collective market share, motive to conspire and opportunity to do so are more than sufficient to meet their pleading obligations.

In early April, the auto insurers filed reply briefs responding to the plaintiffs' contentions. Perhaps most significantly, those defendants that had argued that the Second Amended Complaint still failed to contain any significant allegations about their specific conduct noted that the plaintiffs' response had failed to refute that assertion in any meaningful way ("Rather than simply admit that they failed to allege anything against the moving defendants under the Sherman Act . . . plaintiffs point to allegations against the *other* defendants . . . ." *emphasis in original*).

The entire set of motions are now before Judge Presnell for consideration, with the defendants urging the Court to take a "three strikes, you're out" approach to the plaintiffs' case. Whether Judge Presnell will adopt defendants' baseball analogy and dismiss the case, with prejudice, as to all or some of the defendants remains to be seen. What is certain is that this matter will continue to be a significant focus of attention for the entire auto insurance industry over the coming months. Stay tuned.

IOWA SUPREME COURT AFFIRMS RULING FOR HEALTH INSURER IN ANTITRUST DISPUTE

James M. Burns

In late February, the Iowa Supreme Court affirmed a lower court ruling in *Mueller v. Wellmark*, ending a seven year battle over whether the health insurer's agreement with employers operating "self-funded" insurance plans to provide the same rate concessions obtained from providers by Wellmark to these plans constituted a *per se* antitrust violation. Finding that "these arrangements are not the simple horizontal conspiracies that historically have qualified for *per se* treatment," the Iowa Supreme Court rejected the plaintiffs' contention that they were *per se* unlawful.

In explaining its ruling, the Iowa Supreme Court began its analysis by stating that "these arrangements are not naked price-fixing arrangements, but are more akin to joint ventures." Specifically, the Court explained that "the self-insured [plans] are not entering into bare agreements to refrain from competing on price with Wellmark – they are buying claims administration services from Wellmark" and that "part of that service consists of Wellmark negotiated pricing." As such, the Court held, "Wellmark is not really competing with these plans." Moreover, the Court continued, "If the only lawful choice for a self-insured employer were the time-consuming process of negotiating individual rates with health care providers . . . almost all employers would avoid self insuring." Because this would eliminate a "possible way to render the health care market more efficient and reduce the cost of health care coverage," the Court was unwilling to declare such an arrangement *per se* unlawful, stating "Why should this additional option for employers be *per se* unlawful?"

In addition, in a ruling that may have implications far beyond Iowa, the Iowa Supreme Court also held that the same principles applied when Wellmark obtains discounts from providers on behalf of out-of-state Blue affiliates. Stating that "similar efficiency-related observations can be made about Wellmark's reciprocal arrangements with out-of-state BCBS licensees," the Court also refused to attach a *per se* label to these agreements. As the Court explained, the challenged arrangement allows Wellmark to "utilize the other licensees' negotiated rates in their respective states, and [those licensees'] can use Wellmark's negotiated rates in Iowa," a relationship that "permits Wellmark to offer a fifty-state product that meets the needs of its customers." For this reason, the Iowa Supreme Court held, *per se* condemnation of the practice was not appropriate. Given that the BCBS licensee relationship is currently the subject of significant litigation elsewhere (most notably in *In re Blue Cross Blue Shield Antitrust Litigation*, MDL 2406), the Iowa Supreme Court's analysis in *Mueller v. Wellmark* is likely to be the subject of significant discussion in the coming months, and constitutes a significant victory not only for Wellmark, but all of the Blues.

INSURER AND PHYSICIAN HOSPITAL ORGANIZATION TURN BACK PROVIDER "REFUSAL TO DEAL" ANTITRUST CASE

James M. Burns

On April 16, Judge James M. Moody Jr. (E.D. Ark.) issued a ruling in *Tri State Advanced Surgery Center v. Health Choice*, dismissing an antitrust claim that Cigna Healthcare and Health Choice, a physician hospital organization, had entered into an unlawful agreement to destroy the business of the plaintiff, an ambulatory surgery center serving the greater Memphis metropolitan area. Specifically, the plaintiff maintained that Cigna and Health Choice, which includes Methodist LeBonheur Healthcare (the largest hospital system in the Memphis metropolitan area), had conspired to harm Tri State by agreeing that Cigna would threaten physicians with expulsion from Cigna's PPO network if they continued to refer patients to Tri State.

In support of its claim, Tri State maintained that the alleged agreement was an anticompetitive boycott of its services, entitled to *per se* condemnation. However, the Court rejected plaintiff's argument, holding that the *per se* rule is limited to *horizontal* agreements to harm competitors, and that while plaintiff had alleged that "Health Choice had made the agreement on behalf of its joint venture partner Methodist, in an attempt to eliminate competition against Methodist," because Methodist was not a defendant in the case, and neither Cigna nor Health Choice was a competitor or Tri State, this allegation was insufficient. Accordingly, plaintiff's claim was required to be assessed under the rule of reason.

Examining plaintiff's allegations under the rule of reason, the Court then held that Tri State's allegations were insufficient as a matter of law. Required to show either "market power or proof of actual detrimental effects," Tri State's complaint did not measure up. First, the Court held that Tri State's allegations of detrimental effects were inadequate, because Tri State did not allege that patients could not obtain ambulatory surgery services elsewhere in the region, and that Tri State "is still in business and all its services [remain] available to patients."

Turning next to whether Tri State had sufficiently alleged market power (which would permit a presumption of harm), the Court held that Tri State's allegations in this regard were also inadequate. The relevant product market for Tri State's claim was *not* patients covered by Cigna insurance, but the market for all patients requiring surgical services that do not require hospitalization. Because plaintiff's complaint did not contain any market share information related to *this* market, and because Cigna holds only a 42% share of the commercial insurance market in the area, plaintiff's allegations failed as a matter of law.

In addition, finding that "the deficiencies [in Tri State's] complaint are inherent in the nature of the claims and not likely to be cured by further pleading," Judge Moody dismissed Tri State's antitrust claim *with* prejudice. Judge Moody then declined to exercise supplemental jurisdiction over the plaintiff's state law claims, dismissing them without prejudice. Whether Tri State will appeal the ruling is unclear at this time.